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A University Department of Family Medicine After Ten Years

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The Department of Family Medicine at the University of Washington was started ten years ago after a major curriculum change in the medical school placed new emphasis on education and training of family physicians for the surrounding region in Washington, Alaska, Montana and Idaho (WAMI). This department has organized active programs in patient care, teaching and research at the university base and in a number of affiliated community sites throughout the region. The department is well accepted within the mission of the medical school. Almost a third of graduating medical students choose postgraduate training in family practice. Almost 90 percent of the graduates of the ten programs within the department's network of family practice residencies are established in active family practices, with more than two thirds settling in the WAMI region. Follow-up studies show that these graduates feel well prepared for their practices; are providing a broad range of services in rural, suburban and urban settings; are typically involved in partnership or group practice; and are generally well satisfied with their personal and professional lives.

BEFORE THE RECOGNITION of family practice as the 20th specialty in US medicine in 1969, family practice had no formal place in medical education and lacked an organized base in most medical schools. The first decade of the specialty's development has recently been completed and the situation today is quite different. There are academic departments of family practice in 94 of the 130 medical schools in the country and family practice divisions or programs in another 20 medical schools. It is now possible to assess and characterize the roles of established departments in patient care, teaching and research.

Some fundamental questions were inevitably encountered and addressed by the founders and developers of departments of family practice in medical schools: What kind of role should this new department have in patient care? Should it be based in the academic medical center itself or in a community setting? What role should the department play in undergraduate medical education? How can family practice gain access to an already full and highly structured curriculum? How should graduate training in family practice be organized? Will such residency training meet

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ABBREVIATIONS USED IN TEXT

CME=continuing medical education
WAMI=Washington, Alaska, Montana and Idaho

the future practice needs of graduates? Can student interest in family practice be developed and sustained? Can sufficient numbers of qualified faculty be recruited, and what mixture of background and skills is needed? How can a university-based department of family practice develop and maintain ties with the community served? What kinds of linkages are desirable with other university resources? What kinds of research are needed in family practice, and how can an active research program be organized? Will the graduates of the department's residency programs locate in areas of need? Will they be challenged by and satisfied with their practices? Can the new department of family practice gain acceptance in the competitive and sometimes hostile environment of an academic medical center traditionally more oriented to tertiary care and research than to primary care?

Each academic department of family practice has addressed these questions and developed its own structure and activities within the constraints of available resources, institutional needs and support, and local patterns of patient care and teaching. Although there is considerable diversity among departments of family practice in US medical schools, the objectives and roles of these departments are quite similar. The literature to date is devoid of a published account of the profile and experience of an established academic department of family practice in this country. This paper will therefore describe the ten-year experience of the Department of Family Medicine at the University of Washington School of Medicine. The purpose of this paper is threefold: (1) to summarize the overall development of the department by describing its activities in patient care, teaching and research, (2) to present some benchmarks of the effectiveness of departmental programs and (3) to outline some of the lessons that have been learned from this experience.

Evolution of the Department

An Overview

The Department of Family Medicine of the University of Washington had its inception in the medical school's curriculum change of 1968, which placed major emphasis on education and training of family physicians for the state of Washington and the surrounding region. Subsequently, in the summer of 1970, it became a division of the Dean's Office (Division of Family Medicine) and in February 1971 departmental status was conferred. At that time it was approximately the tenth such department in a United States medical school.

With the advent of a new curriculum in 1968 at the University of Washington School of Medicine, four curricular pathways were created for students: family physician, clinical specialist, behavioral scientist and medical scientist. Over the years, the family physician and clinical specialist pathways have attracted a majority of students from each medical school class. The behavioral scientist pathway was discontinued in 1978 due to limited student interest. The medical scientist pathway has attracted a small number of students pursuing concurrent MD-PHD degrees.

As the only medical school for the four-state region of Washington, Alaska, Montana and Idaho (WAMI), the University of Washington became heavily involved in decentralized regional medical education with the development of the WAMI program in 1970.[1] Gradually the class size was increased from 85 to 175, with a total of 50 positions in each class allocated to applicants from Alaska, Montana and Idaho. As a major part of this program, clinical clerkships were assembled for medical students throughout the WAMI region involving the departments of family medicine, internal medicine, pediatrics, obstetrics-gynecology and psychiatry. Thus, two major shifts in the medical school's mission—a new curriculum favoring flexibility and primary care options, and an expanded regional focus—provided impetus to the evolution of family medicine.

Faculty

In the earlier years of the Department of Family Medicine, faculty were recruited primarily from community practice. In recent years, as family practice residencies and faculty development fellowship programs have become established, a number of new faculty members have joined the department after completion of these kinds of training programs, and actual practice experience is now more variable. Because family medicine is a relatively low clinical income specialty compared with other more procedurally oriented departments, a solid base of institutional

TABLE 1.—*Funding Sources for University of Washington Department of Family Medicine Faculty 1980-1981, Based on Full-time Faculty Equivalent (FTE)**

Academic Rank	Funding Sources: Washington State Budget (FTE)	Alaska, Montana and Idaho (FTE)	Granting Agencies (FTE)	Total
Professor	2.0	..	..	2.0
Research Professor	..	..	.4	.4
Associate Professor	6.0	..	..	6.0
Assistant Professor	3.0	3.4	3.6	10.0
Research Assistant Professor	..	..	.5	.5
Clinical Assistant Professor	..	..	.6	.6
Clinical Instructor	..	..	.5	.5
Research Associate	..	..	1.75	1.75
TOTAL	11.0	3.4	7.35	21.75

*Includes training grants from W. K. Kellogg Foundation, Robert Wood Johnson Foundation and the Department of Health and Human Services, Public Health Service, Health Resources Administration, Bureau of Health Manpower.

support has been required to recruit and retain faculty. The current distribution of the full-time, university-based academic faculty by rank and funding source is shown in Table 1.

In order to carry out the sizable teaching commitments of the department for both medical students and residents throughout the WAMI region, a large clinical faculty has been developed. There are now more than 220 clinical faculty members in the department, most of whom are active in family practice in the community. About 20 of these are in full-time teaching in affiliated family practice residency programs through the support of their own institutions or through state funds appropriated to the university for allocation to these residency programs.

Patient Care

To provide a teaching and research base in the medical school, it was considered essential to develop and maintain an active university-based clinical service in family medicine. Accordingly, a Family Medical Center was built contiguous to the University Hospital on the ground floor with convenient patient access. This unit functions as an autonomous group teaching practice involving faculty, residents and students. Together with the family medicine inpatient service, it provides a visible family medicine presence in the medical school, thereby enhancing the exposure of medical students and other faculty to this discipline.

The Family Medical Center has 15 examination rooms, a waiting-reception area, a small office laboratory, a minor surgery room, a conference room and business offices. Medical records are maintained separately from the hospital on a problem-oriented and family basis. The focus of the practice is on continuity and comprehensiveness of care. Consultation is readily available from the other clinical departments on both an ambulatory and inpatient basis, and during the academic year 1980-1981 the consultation rate was 15 percent.

The Family Medicine Inpatient Service is nongeographic within the university hospital, having access to beds on several medical floors, labor and delivery areas and the newborn nursery. During the 1980-1981 academic year, there were 534 patients admitted to the hospital on this service, including 166 obstetric patients.

Because of various constraints including space limitations, availability of faculty and staff and extensive commitments of the faculty in teaching and research, the maximal clinical volume of the Family Medical Center is estimated at about 20,000 patient visits a year. Over the last ten years, the teaching practice has grown steadily and already exceeds 18,000 patient visits a year. The Family Medical Center now comprises about 13 percent of all outpatient visits.

An important goal in the initial planning of the department's clinical service was the development of a broad-based patient population representative of the community in terms of age, sex, ethnic and socioeconomic distribution. The department provides ongoing primary care for approximately 6,500 patients (2,500 families). The age distribution of the practice population reflects the general Seattle population, with about 28 percent of the patients younger than 18 years of age and 10 percent older than 60 years of age. About 60 percent of the patients are female, reflecting the higher rate of visits by women that is customarily seen in primary care. In terms of third-party coverage, 60 percent of the practice is covered by private insurance, 24 percent by Medicaid, and 11 percent by Medicare.

Education

Undergraduate. The Department of Family Medicine's first educational efforts were directed to the development of an undergraduate teaching program for medical students, which was launched two years before a residency program was started. Since then, a sizable undergraduate teaching program has been developed with elective offerings

TABLE 2.—*The Family Practice Residency Network, University of Washington, as of 1981-1982*

Program Sites	*Number of Residents*	*Year Started*
University Hospital, Seattle	18	1972
Doctors/Swedish Medical Center, Seattle	24	1972
Group Health Cooperative, Seattle	12	1972
Family Medicine Spokane	19	1972
Madigan Army Medical Center, Tacoma	25	1972
Providence Medical Center, Seattle	12	1974
Family Medicine Yakima*	12	1975
Southwest Idaho, Boise	18	1975
Family Medicine Tacoma	12	1978
Naval Regional Medical Center, Bremerton	10	1981
TOTAL	162	

*The Yakima program is a "one-and-two" program, with the first year in Spokane hospitals and the next two years based in Yakima.

in all four years of the medical school's curriculum. Although the required first-year course, Introduction to Clinical Medicine, is an interdisciplinary, nondepartmental course, family medicine faculty have chaired this course for seven years and play a major role in teaching. Other teaching activities during the preclinical years include an introductory family medicine preceptorship (half a day per week for one quarter of the first year) and a continuity family medicine clerkship (half a day per week for three quarters of the second year). Both of these courses are conducted jointly with clinical faculty members practicing in the community.

The family physician pathway has consistently attracted approximately half of each class over the years.[2] The two major differences between this and the clinical specialist pathway are (1) the requirement of a family medicine clerkship and (2) the active involvement of family medicine faculty role models as advisors to students in the family physician pathway.

The family medicine courses during the clinical years are decentralized to a variety of teaching sites throughout the WAMI area. The third-year six-week basic clerkship in family medicine is conducted at University Hospital and in all of the affiliated family practice residency programs. The six-week community clinical clerkship in family medicine is offered during the latter part of the third year and throughout the fourth year in one of eight group practices in the WAMI area. Six of these practices are located in small towns and rural communities—Anacortes and Omak, Washington; Ketchikan, Alaska; Kalispell and Whitefish, Montana; and Pocatello, Idaho—while the other two teaching groups are located in larger communities of Washington (Spokane) and Alaska (Anchorage). In addition, a fourth-year family medicine preceptorship of variable length is offered in several underserved National Health Service Corps and Indian Health Service sites in the WAMI region, and some elective preceptorships are also available in selected primary care settings overseas in developing countries.

Family medicine faculty have contributed regularly to other portions of the required preclinical curriculum, including courses entitled Musculoskeletal System, Behavioral Systems, Ages of Man, Epidemiology, and an elective course entitled Medicine, Health and Society. In addition, a family medicine research elective has attracted a number of students, particularly during the last several years.

As is the case with many medical schools, an intensive reassessment of the medical school's curriculum has recently taken place. Several revisions of the curriculum have been made, including termination of the pathway system, definition of a standard core of clinical clerkships for all students, development of new electives and modification of the advising system. Family medicine now has a place in the core clinical curriculum whereby medical students can obtain their required credits through several course options during the second, third, and/or fourth years.

Graduate. From the outset, it was considered important to establish residency programs in varied settings and to decentralize the locations. The family medicine residency program at University Hospital was started in July 1972. Before that, two other family medicine residencies had been started in Seattle: the Group Health and the Doctors' Hospital programs (1969 and 1970, respectively). Family Medicine Spokane, with three participating hospitals in Spokane, was also begun in 1972. These three programs were formally affiliated with the university in that year. In 1974 a fourth affiliated program in Seattle was started at Providence Hospital and in 1975 two additional affiliated family practice residencies were started in Yakima, Washington, and Boise, Idaho. Three years later an affiliated family medicine residency was started at Tacoma, Washington. More recently, affiliations have been established with two military family medicine residencies at Madigan Army Medical Center in Tacoma and at the Naval Regional Medical

Center, Bremerton, Washington. Table 2 shows the number of residents now in training in these programs, which comprise all of the operational family medicine residencies in the WAMI region.

With the acquisition of a grant from the Kellogg Foundation in 1975, together with state funds earmarked for this purpose in Washington and Idaho, a regional network has been established integrating all affiliated family medicine residency programs.[3] The major goals of this network have been as follows:

- Expansion of the network to more nearly meet the needs for both adequate numbers and distribution of family physicians in the WAMI region.
- Sharing of educational and evaluative resources among participating programs to increase the quality of resident training.
- Development of data-retrieval systems for ambulatory and inpatient resident experiences for the purposes of program evaluation, improvement of resident training and research.
- Development of the residency-based Basic Clerkship in Family Medicine for third-year medical students.
- Generation of new research and development activities in specific areas of interest.

Through regular meetings of family medicine faculty in the network, collaborative efforts have been directed to filling various common needs, such as curriculum and faculty development, program evaluation, solving operational problems and coordination of resident rotations and electives.

Continuing Medical Education (CME). The major focus of the department's activities in CME has been a one-week family practice review course, which in recent years has been offered twice each year. Some family medicine faculty have contributed to interdisciplinary CME programs in such areas as sports medicine, office orthopedics, geriatrics, behavioral science and alcoholism. Other departmental programs include the development of self-assessment techniques and self-teaching materials, individualized short-term (two to four weeks) CME programs in selected areas and studies of learning styles and educational needs of practicing family physicians.

Research

The initial priorities during the earlier years of the department's development were necessarily the organization of patient care and teaching programs for both medical students and residents, together with the establishment of interactive linkages with community-based family physicians and teaching programs throughout the WAMI region. In 1977 a research section was organized in the department with three principal functions: (1) It designs and conducts research projects based in family medicine. (2) It acts as a source of consultation and support to members of the full-time and clinical faculty and to the community at large in the area of research and scholarly investigation. (3) It administers a major fellowship training program for postgraduate family physicians through funding from the Robert Wood Johnson Foundation.

An interdisciplinary advisory group to the research section was established early, which includes representatives from the clinical departments and from departments in other schools (for example, biostatistics, epidemiology, health services, behavioral sciences and anthropology). This advisory group, together with an intradepartmental steering committee, has helped to formulate policy for both the research section and the two-year family medicine fellowship program.

Four general themes of research have emerged in the Department of Family Medicine:

- Clinical epidemiology—stressing population-based clinical strategy research and utilizing the resources of the residency network and affiliated WAMI teaching practices.
- Health services research, particularly in rural health care.
- Behavioral medicine—with an emphasis on sociocultural issues and family function.
- Clinical cognition and decision making.

A number of research projects have already been completed or are in progress in all of these areas. A major three-year grant has been received from the National Institutes of Health to support a regional study of physician and patient behavior in the control of insulin-dependent diabetes mellitus. This project involves collaboration with the Department's WAMI teaching group practices and with the University of Washington Diabetes Research Center, and represents a role that the department can effectively play in many applied population-based research projects.

Some Measures of Departmental Impact

Departmental Acceptance

After ten years the Department of Family Medicine has become fully integrated into the

School of Medicine activities in the areas of patient care, teaching and research. Departmental faculty have a substantial role in undergraduate teaching, and the family medicine residency network makes up about a quarter of all house staff positions in University of Washington affiliated hospitals. Considerable interaction and collaboration takes place regularly between the Department of Family Medicine and many other departments. Departmental faculty are active members on major committees in the School of Medicine, such as the Executive Committee, the Academic Affairs Committee, the Admissions Committee and various search committees for departmental chairmen.

Student Interest

A high level of interest in family medicine was achieved early and maintained consistently throughout the 1970's. Table 3 shows the proportion of each class between 1969 and 1980 that selected the family physician pathway. Table 4 shows the proportions of each graduating class from 1972 to 1981 that entered five major categories of internship and residency training. Family practice residencies have continued to attract 25 percent to 33 percent of the graduates, and some of those entering rotating or flexible training programs later enter family practice residencies.

TABLE 3.—*Family Physician Pathway Selection as of 1979-1980*

Year Entered	Graduation Year	Class Size	Family Physician Pathway No.	(%)
1978	1982	177	67	(38)
1977	1981	183	85	(46)
1976	1980	175	89	(51)
1975	1979	172	87	(51)
1974	1978	135	70	(52)
1973	1977	129	60	(46)
1972	1976	120	60	(50)
1971	1975	106	37	(35)
1970	1974	95	38	(40)
1969	1973	84	42	(50)
1968	1972	85	5	

Distribution of Residency Graduates

A total of 267 family physicians have now graduated from family practice residencies in the network. These graduates are distributed as shown in Table 5. About 70 percent of the graduates remain in the WAMI region, with almost 90 percent of these graduates established in family practice. Of the graduates in active practice, 46 percent are in urban communities (more than 100,000 people), 37 percent in rural and small communities (fewer than 25,000 people) and 17 percent in suburban or medium-sized communities (ranging from 25,000 to 100,000 people). Although the family medicine residency network has grown considerably during the last eight years, the annual number of residency graduates is still short of the region's needs.

Quality of Residency Training

There are several measures supporting the overall quality of residency training as provided within the network. At least 400 applications are received each year for the 54 first-year residency positions available. All of the residency programs are fully accredited. The attrition rate from the network during the last five years has been about 3 percent each year, and over 97 percent of graduates have been certified by the American Board of Family Practice. On the basis of a recent graduate follow-up study, with 93 percent responding, most graduates felt adequately prepared for medical practice.[4]

Practice Patterns of Residency Graduates

Based on a survey of 119 of the 128 network graduates through 1978,[4] the following findings are of particular interest:

- Single-specialty, fee-for-service group practice (that is, three or more family physicians) is the most common practice mode, representing 32 percent of graduates, while 10.1 percent are in partnership practice and 17.7 percent have chosen solo practice; an additional 8.4 percent of

TABLE 4.—*Choice of Internship and Residency by Percentage of Graduating Class for Years 1972 through 1981*

Type of Residency	Year of Graduation 1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Rotating/flexible	28	22	23	9	9	8	9	8	18	9
Family practice	4	28	26	31	27	31	25	28	30	33
Internal medicine	34	34	30	26	28	33	29	28	20	30
Pediatrics	14	6	4	10	6	8	6	6	6	4
Surgery/surgical specialties	10	6	10	9	18	9	8	14	15	17

graduates are in the military or in the National Health Service Corps.

- Five percent of network graduates have entered full-time teaching in either a medical school or a community hospital-based residency.
- The average workweek for full-time family physician graduates is 59.5 hours, including 51 hours in direct patient care, 3.7 hours in continuing medical education and 2.1 hours teaching students or residents.
- Network graduates report a relatively wide spectrum of practice (for example, about 90 percent include obstetrics in their practice).
- All of the network graduates maintain privileges on the active staff of one or more hospitals; of the family physicians practicing full-time, 90 percent are satisfied with their hospital privileges.
- Almost 93 percent of network graduates use problem-oriented medical records; nearly 20 percent use some kind of data-retrieval system.
- Among the graduates in full-time family practice, 41 percent have physician extenders (Medex, physician assistant or nurse practitioner).

TABLE 5.—*Location of Network Graduates as of August 1981*

Remaining in WAMI Region ...		187
Washington	157	
Alaska	7	
Montana	8	
Idaho	15	
Left WAMI Region		70
In private practice	42	
In military	28	
Undecided		10
TOTAL		267
In WAMI Region by activity		
Community practice		
Population less than 2,500		28
2,500-25,000		30
25,000-50,000		24
50,000-100,000		3
100,000+		72
Teaching		
Full-time teaching in family practice residency		6
UW research fellowship		3
Other		
Emergency room		8
Psychiatry		1
Locum tenens and miscellaneous primary care activities		12
TOTAL		187

- About a third of the graduates expressed definitive interest in future research studies in collaboration with the department.
- Graduates of network programs who are in full-time family practice are well satisfied with their personal and professional lives and feel well prepared for most of their practice needs.

Some Lessons From This Experience

The following points emerge as important lessons from the first ten years in the development of the Department of Family Medicine at the University of Washington:

Staged Development and Controlled Growth

It was recognized early that the new department could not address effectively all parts of its mission at once and that priorities for staged development were required. The department's initial activities in 1970 were directed to the development of various undergraduate teaching programs for medical students. In 1972 the university-based teaching practice was begun with the opening of the Family Medical Center, which made possible the start of the university-based residency program. At the same time, the first affiliations were established with three community-based residency programs. In 1975, through support of state funds and a grant from the Kellogg Foundation, a network was established joining the department with all of the community-based family practice residencies in the region. Before a major emphasis could be placed on research, it was necessary to consolidate these programs and recruit additional faculty. With that accomplished, a research section was started in 1977, followed in 1978 by a two-year family medicine fellowship program through funding provided by the Robert Wood Johnson Foundation.

Need for a Strong Faculty Core

In the earlier years of the department, a small cadre of full-time faculty was overburdened with the many demands of patient care, teaching and organization of departmental teaching programs both at the university and at a far-flung group of affiliated community settings. It became clear that additional faculty were needed to help start a research program and to allow a balanced involvement in patient care, teaching, research and administration. At its present faculty size, the department can function effectively in all of these

areas and still allow individual faculty members time for research and related scholarly work.

Value of University-based Practice

The development of a clinical practice in the Family Medical Center and in University Hospital has been a critical step in the progress made by the department in patient care, teaching and research. The university-based practice has allowed physician faculty to maintain practice skills and has provided the patient-care base for a variety of teaching and research activities. The understanding by other faculty in the medical school of the role and training of the family physician has been helped by close proximity to a visible family medicine program. In addition, the importance of family physician faculty being readily available to medical students as teachers and role models cannot be overestimated.

Importance of Complementary "Mix" of Faculty

To maintain the department's clinical base in patient care, it became evident that most of the full-time faculty had to be physicians with enough clinical breadth to attend in the Family Medical Center and on the family medicine inpatient service. Most faculty members are involved in the ongoing care of both adults and children, including obstetric practice; surgical skills are more variable among the faculty and most commonly involve ambulatory minor surgical procedures. Although most of the physician faculty maintain a common core of clinical skills, each also develops expertise in special interest areas (for example, geriatrics, sports medicine, clinical decision making, health services research). It has also been found essential to recruit some full-time nonphysician faculty in other disciplines such as behavioral science (clinical and social psychology), clinical epidemiology and medical education. In addition, some joint and adjunct appointments have been established for part-time faculty based in other departments and schools in the Health Sciences Center.

Continuity of Patient Care for Families

Over the years, some faculty and groups have held various expectations of the potential clinical roles of a family medicine program in this university medical center. For example, the department was asked on several occasions whether it would accept a major clinical and administrative role in the emergency room of University Hospital. On the one hand, this seems a logical request in view of the clinical breadth of the family physician and the integral nature of emergency medicine as one facet of the family physician's training and practice. In other respects, however, emergency medicine is the antithesis of family medicine because of its emphasis on episodic rather than comprehensiveness of care. To limit the clinical commitments of a comparatively small family medicine faculty to a reasonable level without compromising other departmental commitments in teaching and research, it has been necessary to concentrate the department's clinical commitments in the context of long-term comprehensive continuity of care of families based in the Family Medical Center.

Importance of Community Linkages

To carry out extensive and needed departmental teaching programs for both medical students and residents, it has been absolutely essential to develop close affiliations with many community-based practice groups and residency programs throughout the WAMI region. This has provided students and residents with excellent "real world" learning experiences, thereby circumventing the inevitable limitations of large academic centers in primary care teaching. In addition, decentralization of the department's teaching programs has probably played a significant role in achieving high levels of retention of network residency graduates in communities of all sizes throughout the WAMI region. The collaborative relationships that have been established between the full-time university-based faculty and family medicine faculty in community-based affiliated programs and practice have been mutually productive in many ways, including reality-testing of departmental programs, faculty development and, more recently, the initiation of some collaborative research projects.

Quality of Decentralized Teaching Programs

The experience of this department over the last ten years has demonstrated that excellent teaching programs (as measured by student, faculty and peer evaluations) can be established and maintained in decentralized settings away from the university. A number of quality control techniques have been developed to monitor student and resident experience, performance and progress, together with evaluating the overall program.[3,5,6] The cooperative climate that has been

established over the years between university- and community-based faculty should assure the future vitality of these programs.

Importance of Institutional Support

Since family medicine is inevitably a relatively low revenue-generating department in comparison with the more procedurally oriented surgical and medical specialties, a solid base of institutional support is needed for such a department to achieve its goals in patient care, teaching and research. In this instance, patient care revenue supports the operation and staffing of the Family Medical Center only. State funds provide a floor of funding support for about 60 percent of the centrally administered departmental budget, including about half of faculty salaries and the salaries of all university-based residents. Extramural grants have provided funding for the salaries of other faculty and staff. The progress that has been made by this department to date would not have been possible without the solid support of the administration and the constructive assistance of other departments in the medical school.

Sustained Student Interest in Family Medicine

There was a feeling by many observers during the late 1960's and early 1970's that family medicine might represent a flash-in-the-pan phenomenon. However, this department's experience has been that of a high level of interest sustained among medical students in this specialty that shows no signs of erosion. This is not surprising in view of the positive correlations that have been demonstrated nationally between increased numbers of students choosing family practice and such factors as the presence of a department of family medicine and full-time family physicians on the faculty.[7]

Residency Graduates Meet Expectations

The results of a recent survey of graduates from the University of Washington Family Medicine Residency Network show that these graduates are meeting public and personal expectations for these programs.[4] Retention in the field of family medicine and in the region served by the network is high, and a broad range of services is being provided by the graduates. They are evenly distributed among communities ranging from rural to urban and maintain active hospital practices. That these graduates have expressed a high level of satisfaction with their personal and professional lives, together with considerable interest in maintaining ties to the department for teaching, research or both, augurs well for the continued effectiveness of these programs.

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